Child's Name _____ CBIS #_____

Date of Birth _____

Individualized Family Service Plan

General Family Information

Primary Language in the Home_____ Child's Primary Language _____

Name _____
Relationship ❑ Parent ❑ Legal Guardian ❑ Surrogate Parent
Address _____
City _____ State ___ Zip _____ County _____
Telephone: Day _____ Evening _____
Best time to call: _____

Name _____
Relationship ❑ Parent ❑ Legal Guardian ❑ Surrogate Parent
Address _____
City _____ State ___ Zip _____ County _____
Telephone: Day _____ Evening _____
Best time to call: _____

IFSP Team

Date and IFSP Type	Team Member	Role	Telephone	Agency Name
Date: _____				
❑ Initial				
❑ 6-month Review				
❑ Annual				
❑ Transition				
❑ Amendment				
Plan Effective				
From: _____				
To: _____				

Amendment Rationale or Transition Type:

Primary Service Coordinator Contact Information: Name_____Mailing Address:_____
City _____ State _____ Zip _____ Telephone: _____ Best time to call: _____

Backup Service Coordinator Contact Information: Name_____Mailing Address:_____
City _____ State _____ Zip _____ Telephone: _____ Best time to call: _____

Date _____

Medical Information

Medical Area	
Vision	Has your child's vision been tested? ❑ no ❑ yes If yes, when and by which doctor? _____ Do you have any concerns about your child's vision? ❑ no ❑ yes If yes, please explain:_____
Hearing	Has your child's hearing been tested? ❑ no ❑ yes If yes, when and by which doctor? _____ Do you have any concerns about your child's hearing? ❑ no ❑ yes If yes, please explain: _____
General Health Status	Does your child have a pediatrician or other healthcare professional you see regularly? ❑ yes ❑ no If so, please give the name and telephone number: Name: _____ Telephone: _____ When was your child's last well check or visit? _____ Does your child have any specialists or other doctors you see regularly? ❑ yes ❑ no If so, please give the names and reason why your child sees him/her: Name: _____ Why: _____ Name: _____ Why: _____ Name: _____ Why: _____ Does your child have any medical concerns or diagnosis? ❑ no ❑ yes If yes, please specify_____ Was your child born early or prematurely? ❑ no ❑ yes If yes, how many weeks early? _____ What medications is your child taking and why? Include any side effects. Were there any concerns about your child or child's mother prenatally or at birth?
Nutrition	Are there any concerns about your child's eating, general nutrition, or growth? ❑ no ❑ yes If yes, please explain.
Dental	Has your child seen a dentist? ❑ yes ❑ no If so, when and by which dentist? _____ Do you have any concerns about your child's dental health? ❑ no ❑ yes If yes, please explain.

Is there anything about your child's health (special equipment, allergies, other mental or physical information) that the team should know about to better plan and provide services to your family?

Present Level of Development

Developmental Area	_____ does this well	_____ is learning to do this or needs help with this	Who provided information?
Understanding others and expressing myself ***Communication***			
Playing, Thinking, and Exploring ***Cognitive***			
Moving my body and using my hands ***Motor***			
Emotions, feelings, and interacting with others ***Social-Emotional***			
Eating, drinking, toileting, and doing things for myself ***Adaptive***			

 Date _____

Family and Childcare Routines

By learning about what your child and family commonly does, we can get an idea of what goes well for you, what you find challenging, and how we might help. Routine is just another way of describing what you and your child tend to do throughout most days. So we can better understand each routine, we will talk about what you like about your child's participation, what everyone else does during the routine, what type of help your child needs, and how happy you are with the routine. *Some of the routines that families share include waking, getting ready to go out, meals, playtime, hanging out at home, childcare routines, shopping, chores, visiting others, bath time, bed/nap time, and car trips.*

Routine	What goes well and what doesn't go well for your child and family?	How happy are you with how this goes?
		❑ Very ❑ Somewhat ❑ Not at all Comment:
		❑ Very ❑ Somewhat ❑ Not at all Comment:
		❑ Very ❑ Somewhat ❑ Not at all Comment:
		❑ Very ❑ Somewhat ❑ Not at all Comment:
		❑ Very ❑ Somewhat ❑ Not at all Comment:
		❑ Very ❑ Somewhat ❑ Not at all Comment:
		❑ Very ❑ Somewhat ❑ Not at all Comment:

Who provided information about routines on this page? _____

Date _____

Family Identified Priorities and Concerns

Describe your concerns and what is important for your child and family: _____

_____

_____

Think about the discussion about your family and child and your daily routines to answer the following:

Describe what your child enjoys or works well for your child. *Think about people, places, textures, foods, routines, activities*:_____

_____

_____

Describe what your child does not enjoy or does not work well for your child. *Think about people, places, textures, foods, routines, activities*:_

_____

_____

Describe what your family enjoys: _____

_____

Describe what you find challenging or don't enjoy:_____

_____

Describe activities your family would like to do, but are not able to right now and why you are unable to do this: _____

_____

Describe anything you would like to know more about. *Some ideas are below*. _____

_____

_____

- ❑ Meeting families with a child who has similar needs
- ❑ Finding or working with doctors or other specialists
- ❑ Coordinating or making appointments with agencies
- ❑ My child's delay or disability or diagnosis
- ❑ Finding people who can help me in my home
- ❑ Coordinating my child's medical care
- ❑ How services work or how they could work better for me
- ❑ Planning or expectations for the future
- ❑ Money for costs of my child's special needs
- ❑ Ways to play with my child that may help development
- ❑ Recreation, ways to have fun as a family
- ❑ Child care
- ❑ Support groups
- ❑ Help with insurance
- ❑ Resources that may be available
- ❑ Finding adequate housing
- ❑ Transportation

Family Identified Priorities and Concerns

Date _____

#	Priorities and Concerns	Rank

Date _____

Outcomes for Our Child and Family

What we want to happen *(Including how we will know we are successful)*: Related to Priority # ____

Ideas and Strategies *(Address family strengths and resources first.)*	People who will help and their roles

Is assistive technology needed? ❑ yes ❑ no

Family Review
(Date and Initial in Appropriate Column)

1 No Longer a Need	2 Worse	3 Unchanged; Still a Need	4 Partially Met; Still a Need	5 Need Met;

Is modification or revision to outcome or its associated services needed? ❑ yes ❑ no

Comments:

Date _____

Child and Family Transition Plan

This plan addresses which of the following transitions? ❑ From hospital to home ❑ Between communities
❑ Service in new setting ❑ Exit First Steps before 3rd birthday ❑ Exit First Steps at 3rd birthday ❑ Other transition_____
Is this the official transition conference? ❑ yes ❑ no

What our priorities or concerns are related to this transition:

What we want to happen:

Strategies/Activities *(Include family involvement/exploration of options, lead agency discussion, child preparation, and agency preparation and/or involvement.)*	Target Date	Date Completed	People/Agencies who will help and role

Family Review *(Date and Initial)*	No Longer a Need	Unsatisfied or Worse	Unchanged; Still a Need	Partially Met; Still a Need	Need Met; Satisfied

Referral Activities *(Date and Initial)*	Permission for Records Transfer	Records Sent	Permission for Referral	Referral Initiated

Comments:

Date _____

Summary of Services

Service	Who will do this?	How and where?	Who will pay?	How often and how long?	Begin and End Dates	Total Units
		❑Individual ❑ Group				
		❑Individual ❑ Group				
		❑Individual ❑ Group				
		❑Individual ❑ Group				
		❑Individual ❑ Group				
		❑Individual ❑ Group				
		❑Individual ❑ Group				
		❑Individual ❑ Group				
		❑Individual ❑ Group				

All of the services provided by First Steps must be provided in places where children without disabilities would participate unless outcomes cannot be achieved satisfactorily in these environments. These places include home, childcare, or other places in the community. Are all services to be provided in natural environments? ❑ yes ❑ no If no, please provide a rationale for each exception:

Team Approval

Parental Consent for Provision of Early Intervention Services and Approval of the Plan:
The following rights, procedural safeguards, and assurances have been explained to me, and I have received a written copy of each:

❑ Informed Consent ❑ Written Notice of Rights ❑ Confidentiality ❑ Access to Records ❑ Dispute Resolution ❑ Right to Refuse Services

❑ *I have participated in developing this IFSP, and all services and activities have been fully explained to me.* ❑ *I give my informed consent to carry out the plan. I understand my consent is voluntary and I can change my mind and revoke my consent for any or all services and activities at any time.*

❑ *I give my informed consent for a copy of this IFSP in its entirety to be provided to all members of the IFSP team.*

_____ _____
Signature Date

_____ _____
Signature Date

Other Team Members' Approval of Plan:
We agree that the outcomes selected reflect family priorities and concerns and the strategies selected support those outcomes. We agree to carry out the plan in a manner that supports the family's ability to help their child participate in and learn from their everyday routines and activities.

Signature (or printed name if not in attendance)	Date	Approval Method			
		Attended	Phone	Face-to-face	Written
		√			

Others Present:		

Date _____

Assistive Technology

What assistive technology is needed? _____

This assistive technology is related to which outcome(s)? _____

How will the assistive technology help achieve the associated outcome(s)? _____

_____

Does the needed assistive technology exist in the family's natural environment? ❑ Yes ❑ No

Is the assistive technology needed something all children use? ❑ Yes ❑ No

Is there something in the child's natural environment that could be used or adapted to serve the same purpose? ❑ Yes ❑ No

How will the assistive technology be acquired? ❑ Borrowed ❑ Purchased* ❑ Other _____

*If purchased, estimated Cost _____

*Is Assessment needed? ❑ No ❑ Yes Why? _____

Assessor: _____ Date: _____

Will the equipment permanently belong to the family? ❑ Yes ❑ No If no, when must it be returned and to whom? _____

_____

Review			
AT is Being Used	AT is no longer needed	AT is helping with associated outcome(s)	Comments:

AT=Assistive Technology

Date _____

Worksheet to Embed Ideas and Strategies into Routines

Routines *from family and childcare routines*	Child Outcomes *from the Outcomes pages*			

Child's Name_____CBIS#_____

Appendix _____